



CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION
BOARD OF MEDICAL PRACTICE

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV

VERIFICATION OF MEDICAL EDUCATION

Physician applicants who are *not* using the FCVS service should send this form to each medical school attended.

Educational Institution: _____		Applicant Name: _____															
Address: _____		Home Address: _____															
City/State/Zip: _____		City/State/Zip: _____															
This section is to be completed by applicant.	Last Name: _____ First: _____ Middle: _____																
	SSN: _____ Birth Date: _____																
	Other Name(s) Used: _____																
	Applicant Signature: _____ Date: _____																
This section to be completed by Institution.	1. Enter periods that the applicant named above was enrolled in institution:																
	<table border="1"><thead><tr><th>YEAR</th><th>FROM (mm/dd/yyyy)</th><th>TO (mm/dd/yyyy)</th></tr></thead><tbody><tr><td>1</td><td></td><td></td></tr><tr><td>2</td><td></td><td></td></tr><tr><td>3</td><td></td><td></td></tr><tr><td>4</td><td></td><td></td></tr></tbody></table>			YEAR	FROM (mm/dd/yyyy)	TO (mm/dd/yyyy)	1			2			3			4	
YEAR	FROM (mm/dd/yyyy)	TO (mm/dd/yyyy)															
1																	
2																	
3																	
4																	
2. Was the applicant awarded a degree? Yes <input type="checkbox"/> No <input type="checkbox"/>																	
<ul style="list-style-type: none">If <u>yes</u>, enter: Degree Received: _____ Date (mm/dd/yyyy) Degree Conferred: _____If <u>no</u>, attach explanation of reason applicant did not receive a degree.																	
AFFIX INSTITUTION OR NOTARY SEAL HERE	I certify that the information above is an accurate account of the applicant's records and is true and correct.																
	Printed Name of Institution Official: _____																
	Signature of Official: _____ Date: _____																
	Title: _____																
	Phone: _____ Fax: _____ Email: _____																

Mail (do not fax) completed, signed and sealed form *directly* to the Board office at the address above.